W/CB Scant blood

EVI[C] [C]E AND INFO[R] [MA]TION, AND T[O] [DI]SCLOSE PROTECTED HEALTH INFORMATION

2930

Date: 2/10/18

To: Willis Knighton South
HOSPITAL or other HEALTH CARE PROVIDER

Re: [redacted] 10/1/13
PATIENT'S NAME, DOB, and Other Identifying Information

All information that has been gathered on an individual is personal and private. You are not required to release this information.

I understand that the hospital or health care provider listed above will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized written permission, except as required by law. I understand that my records are personal and private; however, I give my permission for the hospital or health care provider listed above to release **a certified copy** of this information to the investigating agency/ agencies that requests copies, including any results of any HIV tests. The above-listed information is to be released for the specific purpose of assisting the District Attorney and other law enforcement agencies in an active criminal investigation in which the records requested are necessary. I understand that my permission to release this information may be cancelled at any time except when information has already been released. My permission to release this information will expire **120 days** from the date listed above. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

If not signed by the patient (due to infirmity, minority, or other mental, physical or legal debilitation), I hereby certify that I am the parent/guardian/representative of the person listed above and have the legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

I further freely consent to allow Olivia Jones, RN, BSN, SANE-A to conduct a forensic examination to collect evidence concerning a sexual assault. DNA profiles derived from evidence in the kit will go into a DNA Database called CODIS (Combined DNA Index System), whereas my DNA profile will stay in the Local DNA Index System (LDIS), and the DNA profile attributable to the offender will be uploaded to the National DNA Index System (NDIS).

The exam procedure for the collection of a PERK (Physical Evidence Recovery Kit) has been fully explained to me and I agree to the following:

- ☑ Yes ☐ No — I authorize the facility/hospital and its agents to release the laboratory specimens, medical records, and related pertinent information of this incident to appropriate law enforcement officials.
- ☑ Yes ☐ No — I release and hold harmless the facility/hospital and its agents from any and all liability and claims of injury in pursuance of evidence collection.
- ☑ Yes ☐ No — I authorize the taking of photographs and understand that the photographs will be released **only** to the appropriate law enforcement officials upon written request.
- ☑ Yes ☐ No — I agree to the examination, including examination of the genitalia and anus.
- ☑ Yes ☐ No — I agree to the collection of specimens for medical investigations to diagnose any medical problems related to this incident.
- ☑ Yes ☐ No — I agree to the collection of specimens for criminal investigation.
- ☑ Yes ☐ No — I agree to provide a verbal and/or written statement to police or other investigators. N/A
- ☑ Yes ☐ No — I agree to have blood drawn for HIV testing. per doctor
- ☑ Yes ☐ No — Do you give permission for the SANE program and/or the hospital to notify and bill your health insurance for your forensic medical exam.

Initial Copy
Final Draft available after
Peer Review

CVR

X [signature]
PATIENT SIGNATURE (or Parent/Guardian/Representative)
(Mother)

X Julie Bolding RN
WITNESS SIGNATURE

X Julie Bolding RN
WITNESS PRINTED NAME

Address: 3011 Kittylane Apt B Shpt, LA. 71107

Phone: (318) 210-3821

White (Hospital/Physician Records) Yellow (Kit Box) Pink (Police Department)

EXHIBIT
S

WILLIS-KNIGHTON MEDICAL CENTER
SHREVEPORT, LA
EMERGENCY ROOM REGISTRATION INFORMATION (3008)

NAME: H[redacted],[redacted] ACCT. NO: B30036697651

GUARANTOR: ALEXANDER,JENNIFER
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821

NEXT OF KIN: ALEXANDER,JENNIFER
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821 RELATION: PARENT

GUAR EMPLOYER: CHILD
ADDRESS:
PHONE:

ARRIVED FROM: A
ATTENDING PHYS: Horan, John J M.D.
ADMIT/OTHER PHYS:
PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	H[redacted],A[redacted]	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: B30036697651
ROOM:
STATUS: REG ER

DATE: 02/10/18
TIME: 0724
SERV/LOC: ERB

UNIT#: C000382302
F/C: MA
SS#: 338-89-3614

PATIENT: H[redacted],A[redacted]
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821
COUNTY: CADDO PARISH

BIRTHDATE: 10/01/13
AGE: 4Y
SEX: F
RACE BLACK OR AFRICAN AME
RELIGION: Other
MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT
ADDRESS: 2305 MARIAN PL
SHREVEPORT,LA 71109
000-0000

PERSON TO NOTIFY: ALEXANDER,JENNIFER
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821 RELATION: PARENT

Is the Patient here for Pre-Op Testing: N
Comments:
Admit Clerk: JACKSJ1.A
Reason for Visit: CPR
Baby ID#:
Known Drug Allergies: U HIPPA Notice Given: Y Date Notice Given: 09/23/14 Device Id: AMBPC6
Interpreter ID Number: Patient Survey: N Preferred Language: ENGLISH Ethnicity: NHILAT
Do you have an advaced directive that you would like to present to us today? N

FOLLOW UP INSTRUCTIONS

_____ GYN follow-up or call _____ for test results

_____ Private Physician

__✓__ Counseling when ready

__✓__ CARA Center (appt. will be made by the police department)

__✓__ Gingerbread House (appt. will be made by the police department)

An appointment is not required for the University Health Women's Clinic if you arrive between 7:30-8:30 am, Monday-Friday.

An appointment can be made by calling the Women's Clinic at 626-0018 or by calling 626-0000 and ask to speak with the Women's Clinic.

If it is recommended that you be tested for HIV follow-up at:

6 weeks_____, 12 weeks _____, & 24 weeks _____ post exam.

If you have not been vaccinated against hepatitis you will need to get your first dose after your initial exam. The next doses will be due in 1-2 months & 4-6 months. You will need to complete a series of 3 vaccines.

STI Prophylaxis recommended at this exam:

Will f/u c Plan MD.

☐ Azithromycin (Zithromax) 1 gram—single dose—by mouth

☐ Metronidazole (Flagyl) 2 grams—single dose—by mouth

Contraindicated if in first trimester of pregnancy; UPT should be verified prior to administration

☐ Ceftriaxone (Rocephin) 250 mg—single dose—IM

***Do NOT drink alcohol for 48 hours if you were given Metronidazole (Flagyl)**

Labs Pending GC/Ct

Emergency Contraception recommended at this exam:

N/A ☐ Plan B, My Way, Take Action, My Way, Aftera, Ella, etc.

☐ _____ emergency contraception given at this exam

APPLICATION FOR CRIME VICTIMS REPARATIONS

CRIME VICTIMS REPARATIONS BOARD
1885 Wooddale Boulevard, Room #1230
Baton Rouge, LA 70806
(225) 925-4437 or (888) 6-VICTIM (Nationwide Toll-Free) www.lcle.state.la.us/cvr

THIS BOX IS TO BE COMPLETED BY THE SHERIFF'S CLAIM INVESTIGATOR

Date Application Received _____ Parish Code _____ CVR# _____

In order for your application to be processed, you must complete all information on this application form. You have one year from the date of the crime to file this application. If you are filing later than one year, you must attach a letter of explanation. Please remember, the Crime Victims Reparations Board is NOT responsible for your bills.

You do not need an attorney to complete this form. If you need assistance, contact the Sheriff's claim investigator or Crime Victims Reparations office at the above-listed telephone numbers. If you choose to hire an attorney to assist you, those fees CANNOT be repaid to you by this program.

When completed, return this application to the Sheriff's office in the parish where the crime occurred. You will be notified by mail when your application reaches the Louisiana Crime Victims Reparations Board office.

VICTIM INFORMATION ☐ Primary ☐ Secondary

Name _____ Social Security # _____

Address _____ City _____

State _____ Zip Code _____

Date of Birth _____ Contact Phone #1 ( ) _____ Unlisted

Contact Phone #2 ( ) _____ Cell Phone ( ) _____

Is victim deceased? _____ Yes _____ No Does victim have children/other dependents? _____ Yes _____ No

Did the victim miss work as a result of crime related injuries? _____ Yes _____ No

Answering questions about the victim's race/ethnic background is voluntary. It will remain confidential.

SEX	AGE of VICTIM WHEN CRIME OCCURRED	ETHNIC BACKGROUND:	Did victim have disability BEFORE the date of the crime?
☐ MALE ☐ FEMALE	_____	☐ Black ☐ American Indian ☐ Asian ☐ White ☐ Hispanic ☐ Alaskan Native	_____ Yes _____ No

CLAIMANT INFORMATION (Complete only if you are responsible for some/all expenses)

LIST ONLY ONE CLAIMANT PER APPLICATION!

Name _____ Social Security # _____

Address _____ City _____

State _____ Zip Code _____

Contact Phone #1 ( ) _____ Relationship to Victim: _____

Contact Phone #2 ( ) _____ Cell Phone ( ) _____

What about services beyond the forensic medical exam?

You may be billed per the provider's standard billing procedures for any services beyond the forensic medical exam. However, you may be eligible to seek reimbursement for those costs from the Crime Victims Reparations Board.

For information regarding what expenses are covered, other specifics and to apply for reimbursement from the Crime Victims Reparations Board, you can visit their website at **www.lcle.state.la.us/programs/cvr.asp** or call their office directly at **(888) 6-VICTIM (842846)**.

Louisiana Department of Health and Hospitals
628 North 4th Street, Baton Rouge, Louisiana 70802
(225) 342-9500 - press option 7

DEPARTMENT OF HEALTH AND HOSPITALS

Guidance

A Survivor's Guide
to Sexual Assault Medical Claims

FORENSIC MEDICAL EXAM

2930

COLLECTION CHECKLIST

The following swabs were collected from H[redacted], A[redacted]
10/01/13 4Y 04M
Do, Giao N M.D. S404
K20034595213 02/10/18

2/10/18
Date of exam

- ☐ KNOWN ORAL
- ☐ KNOWN BLOOD
- ☐ ORAL
- ☐ FINGERNAILS (LEFT HAND)
- ☐ FINGERNAILS (RIGHT HAND)
- ☒ BITEMARK/BREAST (R breast/nipple)
- ☒ BITEMARK/BREAST (L breast/nipple)
- ☐ BITEMARK/BREAST_____
- ☒ ADDITIONAL (L neck)
- ☒ ADDITIONAL (R neck)
- ☒ ADDITIONAL perioral area (around lips)
- ☐ ADDITIONAL_____
- ☐ PUBIC HAIR COMBINGS
- ☐ EXTERNAL GENITALIA
- ☐ PERINEAL
- ☐ VAGINAL
- ☐ CERICAL
- ☐ VAGINAL WASHINGS
- ☐ ANAL

Swabs collected by [signature] SANE's signature

EXAMINATION REQUEST & AUTHORIZATION TO COLLECT

I, JEFF AILDAY #213 representative of the SPD
Sex Crimes Investigator printed name & badge number *Law Enforcement Agency*

hereby request and authorize:

responding Officer Mills SPD
Pick Room #4
LaShunda Prim
1205

2930

- ● Physical Evidence Recovery Kit (PERK)
- ○ Swabs Only
- ○ Forensic Photography Only

H[redacted], A[redacted]
10/01/13 4Y 04M
Do, Giao N M.D. S404
K20034595213 02/10/18

10/1/13
Date of birth

[illegible], BSN, SANE-A
Examiner's Printed Name

2/10/18
Date of exam

Sex Crimes Investigator's Signature

EVIDENCE TRANSFER & CHAIN OF CUSTODY

18-023139
Case Number

2/10/18
Date PERK collected

Kit collected and maintained by SANE Olivia Jones-Spo, BSN, SANE-A

Kit/clothing/swabs transferred and accepted by J. AILDAY ***with*** SPD
Sex Crimes Investigator/LE name *Police department/Sheriff's office*

Date & Time of Transfer 2/10/18 @ 1330

FORENSIC SEXUAL ASSAULT EVALUATION FORM

2930

PERTINENT MEDICAL HISTORY

Patient Name: A[redacted] H[redacted]

Sex: Fe Race: Black Age: 4 DOB: 10/1/13

Current Medications: Delsym (steroid puffs) singulair, albuterol pump

Allergies: fish, seafood, codeine

Date of LMP: N/A Currently pregnant? ☐ Yes ☐ No ☐ Unsure

Last consensual intercourse (date/time): Body cavity:

Contraceptive use: ☐ Yes ☐ No Contraceptive type:

Was shower, douche, or bath taken between assault and last consensual intercourse? ☐ Yes ☐ No

If yes, date and time:

Tubal ligation/hysterectomy:

Past medical history, surgeries and/or pre-existing physical injuries:

unable to answer

Any recent (60 days) anal or genital injuries, surgeries, diagnostic procedures, or medical treatment which may affect physical findings? no

Physical disabilities? ☐ Yes ☒ No Mental disabilities? ☒ Yes ☐ No

If yes, describe: mental - autistic

Physical injuries and/or pain described by patient: unable to assess pt is intubated

PATIENT'S DEMEANOR (check all that apply):

☐ Quiet	☐ Tense	☐ Tearful	☐ Sobbing	☐ Trembling
☐ Agitated	☐ Anxious	☐ Smiling	☐ Angry	
☐ Good Eye Contact	☐ Poor Eye Contact	☐ Responsive to Questions	☒ Intubated c sedation off for 1 hour c the start of exam	

Any voluntary alcohol use within 12 hours prior to assault? ☐ Yes ☐ No ☐ Unsure

Any voluntary substance use within 96 hours prior to assault? ☐ Yes ☐ No ☐ Unsure

If yes, name of substance:

Involuntary ingestion of alcohol/substance? ☐ Yes ☐ No ☐ Unsure

If yes, name of substance:

Loss of memory? ☐ Yes ☐ No ☐ Unsure

Toxicology kit completed? ☐ Yes ☐ No ☐ Unsure

If yes, toxicology kit number:

unable to answer

FOR FORENSIC LAB USE ONLY

Case #

Item #

Forensic Examiner's Name [redacted], BSN, SANE-A

Agency Case Number 18-023139

FO NSIC SEXU/ ASSAULT E\ _UATION FO.../

2930

Responding Officer: Mills Agency: SPD

Responding Detective: Allday Agency: SPD

ASSAULT INFORMATION (More detailed information will be asked on pages 4–5.)

Date/Time of Examination: 2/10/18 1205 Location of Exam: WKS PICU

Date/Time of Assault: 2 Location of Assault: _____

Was a condom used? ☐ Yes ☐ No Did cunnilingus occur? ☐ Yes ☐ No

Did ejaculation occur? ☐ Yes ☐ No ☐ Unsure Specify: _____

Did the patient injure the assailant(s) in any way (i.e., bite, kick, scratch, etc.)?

☐ Yes ☐ No Describe: Unknown

Did assailant injure patient in any way (i.e. bite, kick, scratch, etc.)?

☐ Yes ☐ No ☐ Bleeding (Describe: NFO

Was a weapon used or threatened during assault?

☐ Yes ☐ No Type: _____ Specify: _____

Any injuries to assailant resulting in bleeding?

☐ Yes ☐ No Specify: _____

Total number of assailants: _____ Witnesses? ☐ Yes ☐ No If yes, how many? _____

Assailant's Age(s): _____ Assailant's Gender: ☐ Male ☐ Female

Assailant's Race: ☐ White (non-Hisp) ☐ Hispanic ☐ Black (non-Hisp) ☐ Asian ☐ Other: _____

Other Information: _____

Assailant(s) relationship to patient (if more than one assailant, designate relationship of each):

☐ Parent/Step-Parent	☐ Spouse/Live-in Partner	☐ Ex-Spouse/Live-in Partner	☐ Other Relative
☐ Parent's Live-in Partner	☐ Boyfriend/Girlfriend	☐ Ex-Boyfriend/Girlfriend	☐ Date
☐ Acquaintance	☐ Friend	☐ Stranger	☐ Unknown

☐ Other (specify): _____

Were clothes/underwear, worn at the time of the assault, changed prior to exam?	☒ Yes	☐ No	If yes, available?: in PICU trash can and cut up from EMS
Was douche, shower, or bath taken between assault and this examination?	☐ Yes	☐ No	
Has patient urinated since the assault?	☒ Yes	☐ No	DATE/TIME has cont. Foley
Has patient defecated since the assault?	☐ Yes	☐ No	DATE/TIME unknown
Has patient vomited since the assault?	☐ Yes	☐ No	DATE/TIME unknown
Has patient brushed teeth/used mouthwash since assault?	☐ Yes	☐ No	DATE/TIME Oral care @ bedside yet.
Has patient ate or drank fluids since assault?	☒ Yes	☐ No	DATE/TIME earlier evening 2/9/18. Obtains
Has patient removed tampon/pad/sponge/diaphragm?	☐ Yes	☒ No	If yes, available?: N/A

Note all that apply: _____

FOR FORENSIC LAB USE ONLY	
Case # _____	Forensic Examiner's Name [redacted], RN, SANE-A
Item # _____	Agency Case Number 18-023139

FC NSIC SEXU. ASSAULT E. .UATION FO. .1

2930

PATIENT DESCRIPTION OF ASSAULT:

Rec'd care of 4y/o BF lying in PICU bed & orally intubated. CR monitor in place. Per mother pt was in grandmother's custody during episode where she turned blue and 911 was called. Per mother pt was awake & wheezing when grandmother called 911. Consent obtained from mother prior to SANE exam.

Continued on back? ☐ Yes ☒ No

FOR FORENSIC LAB USE ONLY	
Case # _____	Forensic Examiner's Name Quinn, RN, BSN, SANE-A
Item # _____	Agency Case Number 18-023139

FORENSIC SEXUAL ASSAULT EVALUATION FORM

2930

ACTS DESCRIBED BY PATIENT

Penetration of female sexual organs? Used: ☐ Penis ☐ Finger ☐ Mouth ☐ Foreign Object	☐ Yes	☐ No	☑ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Oral copulation of genitals?	☐ Yes	☐ No	☑ Unsure
Offender to patient:	☐ Yes	☐ No	☐ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Patient to offender:	☐ Yes	☐ No	☐ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Oral copulation of anus?	☐ Yes	☐ No	☑ Unsure
Offender to patient:	☐ Yes	☐ No	☐ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Patient to offender:	☐ Yes	☐ No	☐ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Penetration of anus? Used: ☐ Penis ☐ Finger ☐ Mouth ☐ Foreign Object	☐ Yes	☐ No	☑ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Masturbation?	☐ Yes	☐ No	☑ Unsure
Offender to patient:	☐ Yes	☐ No	☐ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Patient to offender:	☐ Yes	☐ No	☐ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Offender to self:	☐ Yes	☐ No	☐ Unsure
Ejaculation:	☐ Yes	☐ No	☐ Unsure
Fondling of patient? Location:	☐ Yes	☐ No	☑ Unsure
Offender licked/kissed patient? Location:	☐ Yes	☐ No	☑ Unsure

Pt Intubated

PHYSICAL EXAM

Temperature Gle, 3 (av) Pulse 114 Respiration 40 Blood Pressure 125/81

HEENT

Neck

Lungs

Chest/Heart

Abdomen

Muscle/Skeletal

Neurological

Skin

Exam deferred so FME could be completed so pt could go to CT.

Body surface injuries? ☐ Yes ☒ No ☐ Unsure

If yes, see body surface diagram (page 5 of 9).

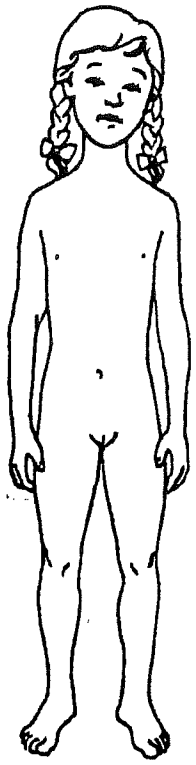
Checked Body for injuries.

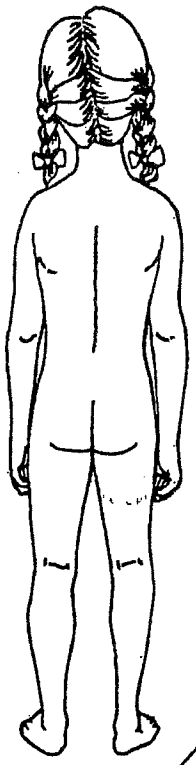
FOR FORENSIC LAB USE ONLY	
Case # _____	Forensic Examiner's Name Quinn, BSN, SANE-A
Item # _____	Agency Case Number 18-023139

FC NSIC SEXU ASSAULT E LUATION FO M

2930

SEXUAL ASSAULT EXAMINATION AND OBSERVATIONS (FEMALE PEDIATRIC BODY)





abrasion
+ bitemark
x bruise
0 burn
• hematoma
/ laceration
^ puncture
* scratch

see photolog

ER – erythema (redness)
EC – ecchymosis (bruise)
AB – abrasion
LA – laceration
BI – bite
MS – moist secretion
DS – dry secretion
TB – toluidine blue
PE – petechiae
DF – deformity
SI – suction injury

Location Number	Type of Injury (Abbreviation)/Description	Location Number	Type of Injury (Abbreviation)/Description

FOR FORENSIC LAB USE ONLY

Case # _____

Item # _____

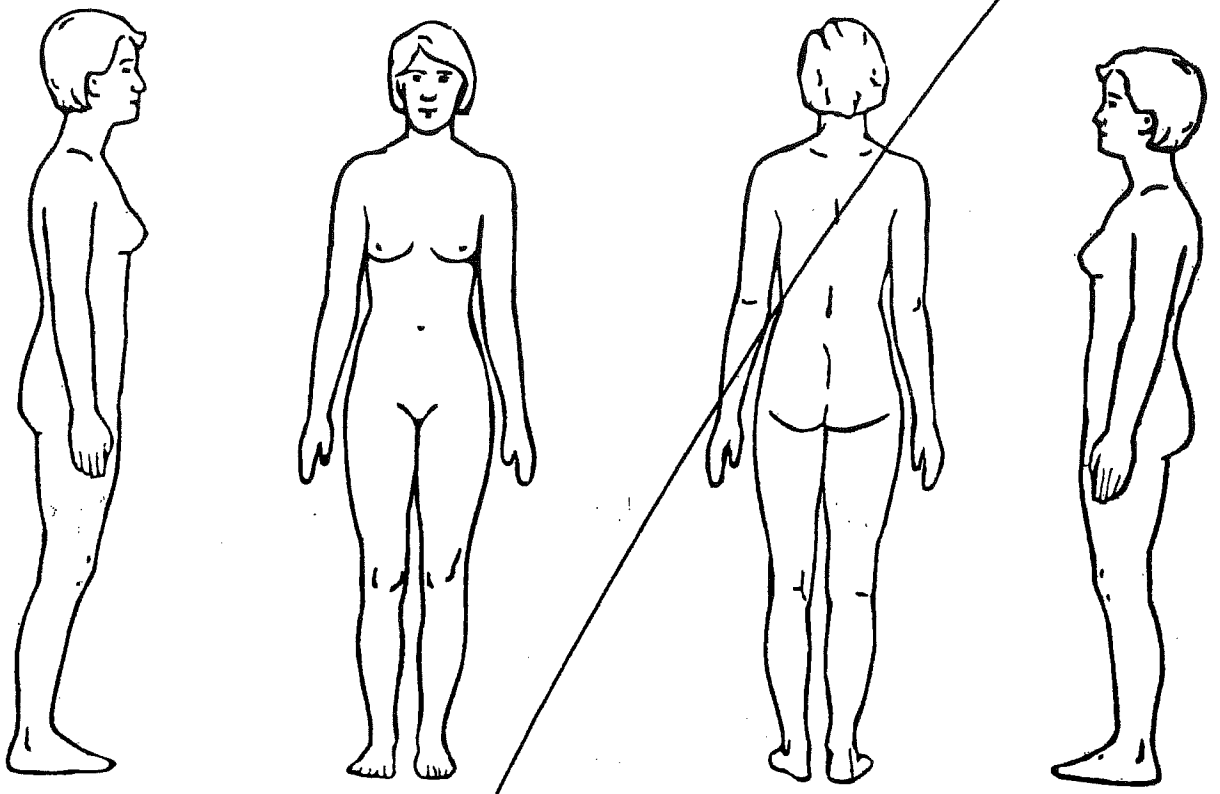
Forensic Examiner's Name Christopher, BSN, SANE-A

Agency Case Number 18-023139

FC :NSIC SEXU ASSAULT E LUATION FO M

2930

SEXUAL ASSAULT EXAMINATION AND OBSERVATIONS (FEMALE BODY)



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SI – suction injury

Location Number	Type of Injury (Abbreviation)/Description	Location Number	Type of Injury (Abbreviation)/Description

FOR FORENSIC LAB USE ONLY

Case # _____

Item # _____

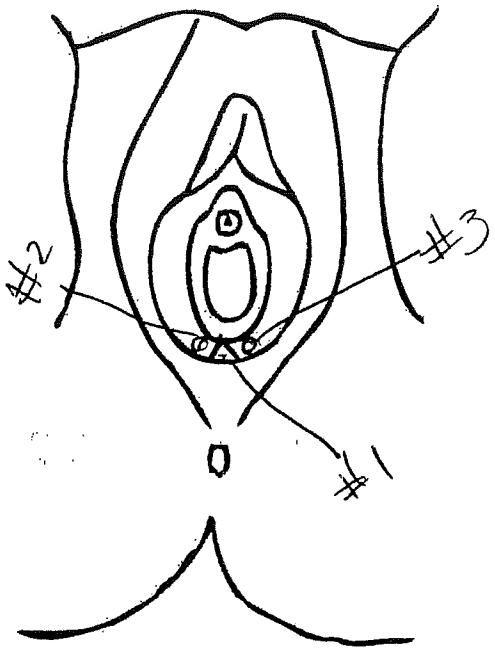
Forensic Examiner's Name _____, BSN, SANE-A

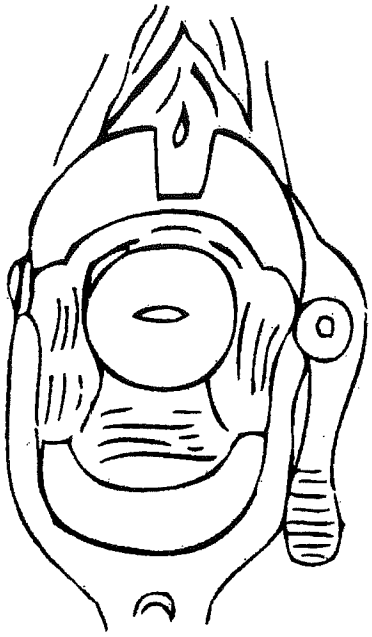
Agency Case Number 18-023139

FORENSIC SEXUAL ASSAULT EVALUATION FORM

2930

SEXUAL ASSAULT EXAMINATION AND OBSERVATIONS (FEMALE GENITALIA)





ER – erythema (redness)
EC – ecchymosis (bruise)
AB – abrasion
LA – laceration
BI – bite
MS – moist secretion
DS – dry secretion
TB – toluidine blue
PE – petechiae
DF – deformity
SI – suction injury

Location Number	Type of Injury (Abbreviation)/Description	Location Number	Type of Injury (Abbreviation)/Description
#1	LA c bld liquid coming from site		
#2	AB		
#3	AB		

FOR FORENSIC LAB USE ONLY

Case # _____

Item # _____

Forensic Examiner's Name Christopher, BSN, SANE-A

Agency Case Number 18-023139

FORENSIC SEXUAL ASSAULT EVALUATION FORM

2930

GENITAL/ANAL EXAMINATION

Position of patient for exam: ☐ Lithotomy ☒ Other (specify) Froglegs

Anal Examination

Buttocks: small amt of stool on outer buttock cheeks

Anus: ∅ TEARS

Anal tone: (D) brisk wink.

Additional comments: →

Colposcopy/Photography

ALS/UV light reaction? ☐ Yes ☒ No reaction ☐ Not indicated

Toluidine dye uptake? ☒ Yes ☐ Negative uptake ☐ Not indicated

CARE PLAN

☐ Powerless related to sexual assault

☐ High risk for post trauma response related to sexual assault

☐ High risk for self-harm related to post-trauma syndrome

☐ High risk for ineffective family coping related to sexual assault/domestic abuse

Plan: Fluc PLW MD & RN. Will give pts information to Project Celebration to follow-up with in the future. Nurse is talking c mother.

REPORT GIVEN TO: Dr Tran - PLW MD

LAB STUDIES

HIV? ☐ Yes ☐ No

RPR/VDRL? ☐ Yes ☐ No

} will refer all testing to PLW MD.

Indicate tests performed below:

GC/Chlamydia: Probe ____ Urine GC/chlly per PLW /UPT ____ UDS per PLW BAC ____

Other lab studies: ____

Radiology studies: CT of head after SANE exam per PLW MD

CLOTHING

Appearance of clothing (at examination): In hospital gown upon SANE's arrival

Underwear collected? ☐ Yes ☒ No If no, explain: ____

List additional clothing collected: ____

FOR FORENSIC LAB USE ONLY	
Case # ____	Forensic Examiner's Name [redacted], BSN, SANE-A
Item # ____	Agency Case Number 18-03139

FORENSIC SEXUAL ASSAULT EVALUATION FORM

2930

AGENCY NOTIFICATION

Notification of advocacy center? ☑ Yes ☐ No If no, explain: unable to decide if SA occurre

Name of Advocate: N/A

DCFS notified? ☑ Yes ☐ No Representative Name: LaShonda Prim- present @ BS

Elder Abuse Report? ☐ Yes ☑ No Representative Name:

Disabled Persons Report? ☐ Yes ☑ No Representative Name:

Interpreter used? ☐ Yes ☑ No Language:

Name of Interpreter:

EVIDENCE RELEASED

Clothing ☐ Yes ☒ No Officer:

Date/Time: Agency:

Forensic Specimens (PERK) ☑ Yes ☐ No Officer: Allday

Date/Time: 2/10/18 @ 1330 Agency: SPD

Forensic Toxicology Kit ☐ Yes ☒ No Officer:

Date/Time: Agency:

Other:

TREATMENT

Was patient an admit to hospital? ☐ Yes ☐ No Already admitted to PICU

HIV Prophylaxis? ☐ Yes ☐ No Recommended Will talk to PICU MD

Emergency contraception? N/A ☐ Yes ☐ No Recommended

Written and verbal discharge instructions? ☑ Yes ☐ No given to mother

Discharged with (check all that apply): ☐ Family ☐ Friends ☐ Police ☑ Other Remains in PICU

ADDITIONAL INFORMATION:

DHH + SANE discharge paperwork given to mother

Crime Victim's Reparation Information given to patient (CVR): ☑ Yes ☐ No

Physician/Sexual Assault Nurse Examiner [redacted], BSN, SANE-A

Date 2/10/18

FOR FORENSIC LAB USE ONLY	
Case #	Forensic Examiner's Name [redacted], BSN, SANE-A
Item #	Agency Case Number 18-023139

FC ENSIC SEXU ASSAULT E LUATION FC M

2930

PHOTOGRAPH LIST: DIGITAL: X Collected to retain COLPOSCOPY: _____ Collected to retain

Forensic photographs were taken during this examination. Photos will be provided to the prosecuting authority upon written request.

Photo #	Description
1	PERK
2	Pt c ETT + bubbles out of (R) nare
3	frontal shot of pt in the bed.
4.	View of IV pumps connected to pt.
5.	(L) view of pt connected to pt.
6.	(R) Forearm - PIV in place., gauze on (R) wrist.
7.	gauze to (R) leg - post IO placement. CVL in (R) groin. Foley + connector on (L) inner thigh.
8.	Foley + connector on (L) inner thigh.
9.	Healed scar to (R) lower outer quad
10.	" " c ruler
11.	Supine. Frog-legged c foley in place. Dried red secretions on bilateral outer labia.
12.	Supine frog-legged c foley - lac to posterior commisure (edge of labia) @ 6 o'clock on a 12 clock. small amt of red secretions draining from site.
13.	" " " " " "
14.	Dye application
15.	Post dye application c (1) dye uptake from 5 o'clock - 7 o'clock on a 12 clock.
16.	(2) dye uptake from 5 o'clock - 7 o'clock to the posterior commisure c separation
17.	" " " " (R) side c traction
18.	" " " (L) side c traction
19.	(R) side lying - soft stool on buttocks. Bottom of laceration extending into upper perineum.
20.	" " " " " c anus & TEARS.
21.	PERK

22. abdomen of pt - (R) injury

23. lower abdomen of pt. - (R) injury

Continued on back? ☐ Yes ☒ No

Initial Copy
Final Draft available after Peer Review

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Forensic Examiner's Name Quinn, RN, BSN, SANE-A

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